RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-25
STANDARDS FOR ASSISTED-CARE LIVING FACILITIES

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1200-8-25-.01 DEFINITIONS.

(1) Activities of Daily Living (ADL's). Those personal functional activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, and moving from one place to another.

(2) Administer. The direct application of a drug to a resident by injection, inhalation, ingestion, topical application or by any other means.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Aged. A person who is sixty-two (62) years of age or older.

(6) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(7) Ambulatory. The resident's ability to bear weight, pivot and safely walk with the use of a cane, walker, or other mechanical supportive device with or without minimal assistance of another person. A resident who requires a wheelchair must be capable of transferring to and propelling the wheelchair independently for purposes of life safety evacuation; otherwise, a resident who requires a wheelchair may receive assistance to transfer and with any other activity of daily living.

(8) Assisted-Care Living Facility (ACLF). A building, establishment, complex or distinct part thereof which accepts primarily aged persons for domiciliary care and provides on site to its residents room, board, non-medical living assistance services appropriate to the residents' respective needs, and medical services as prescribed by each resident's treating physician, limited to the extent not covered by a physician's order to a home care organization and not actually provided by a home care organization. An ACLF may directly provide such medical services as medication procedures and administration that are typically self-administered, limited to oral medications, topicals, suppositories and injections (excluding intravenous) pursuant to a physician's order, and emergency response. All other services (part-time or intermittent nursing care, physical, occupational and speech therapy, medical social services, medical supplies other than drugs and biologicals, and durable medical equipment) that a home care organization is licensed to provide may be provided in the facility only

(Rule 1200-8-25-.01, continued)

by a licensed home care organization, except for home health aide services, or by the appropriate licensed staff of a nursing home if the assisted care living facility is located on the same physical campus as the licensed nursing home, in which case the assisted care living facility shall provide the individual with written notice that such services may be available to the individual as a Medicare benefit through a licensed home care organization.

(9) Assisted-Care Living Facility Resident. Primarily an aged ambulatory person who requires domiciliary care and who may require non-medical living assistance services, medical services such as medication procedures and administration of medications that are typically self-administered, emergency response services, and home care organization services as prescribed by a physician's order and as allowed by law. Except as permitted in these rules, section 1200-8-25-.05, a person shall not be admitted or continue to reside in an ACLF if the person is in the latter stages of Alzheimer's disease or related disorders, requires physical or chemical restraints, poses a serious threat to himself or herself or others, or requires nasopharyngeal and tracheotomy aspiration, initial phases of a regimen involving administration of medical gases, a nasogastric tube, gastrostomy feedings, or arterial blood gas monitoring, is unable to communicate his or her needs, requires intravenous or daily intramuscular injections or intravenous feedings, insertion, sterile irrigation and replacement of catheters (except for routine maintenance of Foley catheters), sterile wound care, or treatment of extensive stage 3 or 4 decubitus ulcer or exfoliative dermatitis.

(10) Board. The Tennessee Board for Licensing Health Care Facilities.

(11) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a resident to make health care decisions while having the capacity to do so. A resident shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a resident shall have the burden of proving lack of capacity.

(12) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(13) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(14) Communication of Needs. Any effective method, verbal or nonverbal, of expressing or exchanging information or query in a mutually understandable form.

(15) Competent. A resident who has capacity.

(16) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:

(a) the action(s) implemented to prevent the reoccurrence of the unusual event,

(b) the time frames for the action(s) to be implemented,

(c) the person(s) designated to implement and monitor the action(s), and

(d) the strategies for the measurements of effectiveness to be established.

(Rule 1200-8-25-.01, continued)

(17) Department. The Tennessee Department of Health.

(18) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(19) Dietitian. A person currently licensed as such by the Tennessee Board of Dietitian/Nutritionist Examiners.

(20) Distinct Part. A unit or part thereof that is organized and operated to give a distinct type of care within a larger organization which renders other types or levels of care. Distinct denotes both organizational and physical separateness. A distinct part ACLF must be physically identifiable and be operated distinguishably from the rest of the institution. It must consist of all the beds within that unit such as a separate building, floor, wing or ward. Several rooms at one end of a hall or one side of a corridor is acceptable as a distinct part ACLF.

(21) Do Not Resuscitate (DNR) Order. An order entered by the resident's treating physician in the resident's medical record which states that in the event the resident suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.

(22) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(23) Emergency. Any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(24) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(25) Evacuation Capability. The ability to either evacuate the building or move to a point of safety.

(26) Extensive Stage 3 Decubitus. A lesion, ischemic ulceration and/or necrosis of tissue with infection or sinus tract formation overlying a bony prominence caused by unrelieved pressure, friction or shear where a full thickness of skin is lost exposing the subcutaneous tissues which presents clinically as a deep crater or greater than five (5) centimeters in diameter with or without undermining of adjacent tissue.

(27) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(28) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(29) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(30) Health Care Decision-maker. In the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with health care decision-making authority, the resident's surrogate as determined pursuant to Rule 1200-8-25-.12 or T.C.A. §33-3-220,

(Rule 1200-8-25-.01, continued)

the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(31) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(32) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(33) Holding Out to the Public. Advertising or soliciting the public through the use of personal, telephone, mail or other forms of communication to provide information about services provided by the facility.

(34) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(35) Individual instruction. An individual's direction concerning a health care decision for the individual.

(36) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(37) Latter Stages. The third stage of a three stage disease.

(38) Licensed nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(39) Licensee. The person or body to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(40) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(41) Medical Record. Documentation of medical histories, nursing and treatment records, care needs summaries, physician orders, and records of treatment and medication ordered and given which must be maintained by the facility, regardless of whether such services are rendered by facility staff or by arrangement with an outside source.

(42) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident.

(43) NFPA. The National Fire Protection Association.

(44) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.

(45) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(Rule 1200-8-25-.01, continued)

(46) Personal Services. Those services that are rendered to residents who need supervision or assistance in activities of daily living. Personal services do not include nursing or medical care.

(47) Personally Informing. A communication by any effective means from the resident directly to a health care provider.

(48) Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

(49) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(50) Primarily Aged. A minimum of fifty-one per cent (51%) of the population of the facility is at least sixty two (62) years of age.

(51) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(52) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the resident's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(53) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(54) Responsible Attendant. The person designated by the licensee to provide personal services to the residents. In the absence of the licensee, the responsible attendant is responsible for ensuring that the ACLF complies with all rules and regulations.

(55) Secured Unit. A facility or distinct part of a facility where the residents are intentionally denied egress by any means.

(56) Social Worker. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and has at least one (1) year of social work experience in a health care setting.

(57) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(58) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(59) Surrogate. An individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident.

(60) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the resident.

(61) Universal Do Not Resuscitate Order. A written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The Physician Order for Scope of Treatment (POST) form promulgated by the Board for Licensing Health Care Facilities as a mandatory form shall serve as the Universal DNR according to these rules.

(Rule 1200-8-25-.01, continued)

(62) Unusual Event. The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition.

(63) Unusual Event Report. A report form designated by the department to be used for reporting an unusual event.

Authority: *T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed January 24, 2006; effective April 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007.*

1200-8-25-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, or any state, county or local government unit, or any division, department, board or agency thereof shall establish, conduct, operate, or maintain in the State of Tennessee any assisted-care living facility without having a license. A license shall be issued to the person or persons named and for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the facility.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the department.

(b) Each applicant for a license shall pay an annual license fee based on the number of ACLF beds. The fee must be submitted with the application and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Residents shall not be admitted to the facility until a license has been issued. Applicants shall not hold themselves out to the public as being an ACLF until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules and regulations.

(d) The applicant must prove the ability to meet the financial needs of the facility.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the new license may be issued.

(a) For the purpose of licensing, the licensee of an ACLF has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the facility's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the facility is owned and operated and any ownership interest of the preceding or succeeding entity changes.

(Rule 1200-8-25-.02, continued)

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the facility's legal title;

2. Lease of the facility's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;

6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate facility owner with one or more corporations; or,

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or,

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the same legal form as the former owner.

(4) Each ACLF, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter shall pay annually to the department a fee based on the number of ACLF beds, as follows:

(a)	Less than 25 beds	$ 800.00
(b)	25 to 49 beds, inclusive	$ 1,000.00
(c)	50 to 74 beds, inclusive	$ 1,200.00

(Rule 1200-8-25-.02, continued)

(d) 75 to 99 beds, inclusive $ 1,400.00

(e) 100 to 124 beds, inclusive $ 1,600.00

(f) 125 to 149 beds, inclusive $ 1,800.00

(g) 150 to 174 beds, inclusive $ 2,000.00

(h) 175 to 199 beds, inclusive $ 2,200.00

For ACLF's of two hundred (200) beds or more the fee shall be two thousand four hundred dollars ($2,400.00) plus two hundred dollars ($200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

(5) To be eligible for a license or renewal of a license, each ACLF shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction must be submitted.

(6) A license shall be issued only for the location designated and the licensee named in the application. If a facility moves to a new location, a new license will be required before residents are admitted. A licensee who plans to relocate must contact the department to inspect the new building prior to relocation.

(7) Any admission in excess of the licensed bed capacity is prohibited.

(8) A separate license shall be required for each ACLF when more than one facility is operated under the same management or ownership.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-210.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed January 19, 2007; effective April 4, 2007. Amendment filed February 23, 2007; effective May 9, 2007.*

1200-8-25-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the facility;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the residents of the assisted care living facility; and

(e) Failure to renew license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(Rule 1200-8-25-.03, continued)

(b) The character and degree of impact of the violation on the health, safety and welfare of the residents in the facility;

(c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,

(d) Any prior violations by the facility of statutes, regulations or orders of the commissioner or the board.

(3) When an assisted care living facility is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of receipt of the statement of deficiencies, the facility must return a plan of correction including the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the assisted care living facility's license to possible disciplinary action.

(5) Following a contested case hearing, the board may find a facility's license subject to suspension or revocation and may then immediately impose any sanction authorized by law.

(6) The department may assess a civil penalty:

(a) Not to exceed five thousand dollars ($5,000) against any person or entity operating an ACLF without having the license required by these regulations. Each day of operation is a separate violation.

(b) Beginning one hundred eighty (180) days after the effective date of these regulations, not to exceed three thousand dollars ($3,000), against any licensed ACLF for admitting or retaining residents not meeting the definition of an ACLF resident set forth in these regulations. Each inappropriately placed resident shall constitute a separate violation.

(7) A contested case hearing shall be held by the board upon appeal by a facility penalized according to paragraph (6) of this section.

(8) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, and 68-11-213.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-8-25-.04 ADMINISTRATION.

(Rule 1200-8-25-.04, continued)

(1) The licensee shall be at least eighteen (18) years of age, of reputable and responsible character, able to comply with these rules, and must maintain financial resources and income sufficient to provide for the needs of the residents, including their room, board, and personal services.

(2) The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee.

(3) Each ACLF must have an administrator who shall be certified by the board, unless the administrator is currently licensed in Tennessee as a nursing home administrator as required by *T.C.A. §§ 63-16-101, et seq*.

(4) An applicant for certification as an ACLF administrator shall meet the following requirements:

(a) Must be a high school graduate or the holder of a general equivalency diploma.

(b) Must not have been convicted of a criminal offense involving the abuse or intentional neglect of an elderly or vulnerable individual.

(c) Must submit an application, on a form provided by the department, and a fee of one hundred eighty dollars ($180) prior to issuance or renewal of a certificate. All certificates shall expire biennially on June 30, thereafter.

(d) Biennial renewal of certification is required. The renewal application and fee of one hundred eighty dollars ($180) shall be submitted with written proof of attendance, during the period prior to renewal, of at least twenty-four (24) classroom hours of continuing education courses approved by the board. The initial biennial re-certification expiration date of Assisted-Care Living Facility administrator candidates who receive their initial administrator certification between the dates of January 1 and June 30 of any year will be extended to two (2) years plus the additional months remaining in the fiscal year. This extension applies only to the first biennial certification period for any such administrator and may only be applied when there are less than six (6) months remaining in the State fiscal year.

1. The twenty-four (24) hours of required continuing education courses shall include instruction in the following:

(i) State rules and regulations for homes for the aged/ACLF's;

(ii) Health care management;

(iii) Nutrition and food service;

(iv) Financial management; and,

(v) Healthy lifestyles.

2. All educational courses sponsored by the National Association of Boards of Examiners for Nursing Home Administrators (NAB) and continuing education approved courses sponsored by State and/or national associations that focus on geriatric care are board approved.

3. In order to obtain board approval for educational courses, a copy of the course curriculum must be submitted to the board for approval prior to attending the course.

(Rule 1200-8-25-.04, continued)

4. Proof of administrator certification course attendance shall be submitted to the department upon completion of the course.

(5) Each ACLF must:

(a) Have an identified responsible attendant and a sufficient number of employees to meet the needs, including medical services as prescribed, of the residents. The responsible attendant and direct care staff must be at least eighteen (18) years of age and able to comply with these rules.

(b) Have a licensed nurse available as needed.

(c) Not employ any person or have any attendant who is listed on the department's Abuse Registry.

(d) Have a written statement of policies and procedures outlining the responsibilities of the licensee to the residents and any obligation of the residents to the facility.

(e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.

(f) Keep a written up-to-date log of all residents and produce the log for the local fire department in the event of an emergency.

(g) Have written policies and procedures informing the resident how to register grievances and complaints.

(h) Not allow an owner, responsible attendant, employee or representative thereof to act as a court-appointed guardian, trustee, or conservator for any resident of the facility or any of such resident's property or funds, except as provided by rule 1200-8-25-.11(9).

(i) Cooperate during inspections conducted by the Department, including allowing entry at any hour and providing all required records.

(j) Ensure that there is an effective facility-wide performance improvement program. The facility must develop and implement a plan for improvement, address deficiencies identified by a performance improvement program and document the outcome for remedial action.

(k) Whenever these rules and regulations require that a licensee develop a written policy, plan, procedure, technique or system concerning a subject, the licensee shall develop the required policy, maintain it, and adhere to its provisions. A facility which violates a required policy also violates the rules and regulations establishing the requirement. Licensed ACLF's must follow all policies, plans, procedures, techniques, or systems whose development is required by these rules.

(l) Not retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Adult Protective Services, or the Comptroller of the State Treasury. A facility shall neither retaliate nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(m) Allow pets in the facility only when they are not a nuisance or do not pose a health hazard and when plans for their management have been approved by the department.

(Rule 1200-8-25-.04, continued)

(n) Comply with all local laws, rules or ordinances, and with the rules and regulations of this chapter.

(6) A registered nurse may make the actual determination and pronouncement of death under the following circumstances.

(a) The deceased was a resident of an assisted-care living facility;

(b) Death was anticipated,, and the attending physician has agreed in writing to sign the death certificate. Such agreement by the attending physician must be present and with the deceased at the place of death.

(c) The nurse is licensed by the state; and

(d) The nurse is employed by the assisted-care living facility in which the deceased resided.

(7) No occupant or employee who has a reportable communicable disease, as stipulated by the department, is permitted to reside or work in an ACLF unless the ACLF has a written protocol approved by the department.

(8) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, *T.C.A. §§4-5-101, et seq*.

(9) All health care facilities licensed pursuant to T.C.A. §§68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

(c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(10) The facility shall have an annual influenza vaccination program which shall include at least:

(a) The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility;

(b) A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;

(c) Education of all direct care personnel about the following:

(Rule 1200-8-25-.04, continued)

1. Flu vaccination,

2. Non-vaccine control measures, and

3. The diagnosis, transmission, and potential impact of influenza;

(d) An annual evaluation of the influenza vaccination program and reasons for non-participation;

(e) The requirements to complete vaccinations or declination statements are suspended by the administrator in the event of a vaccine shortage.

(11) The facility and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include:

(a) Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each patient contact if hands are not visibly soiled;

(b) Use of gloves during each patient contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur and gloves changed before and after each patient contact;

(c) Use of either a non-antimicrobial soap and water or an antimicrobial soap and water for visibly soiled hands; and

(d) Health care worker education programs which may include:

1. Types of patient care activities that can result in hand contamination;

2. Advantages and disadvantages of various methods used to clean hands;

3. Potential risks of health care workers' colonization or infection caused by organisms acquired from patients; and

4. Morbidity, mortality, and costs associated with health care associated infections.

(12) The facility shall develop and implement a system for measuring improvements in adherence to the hand hygiene program and influenza vaccination program.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-3-511, 68-11-257, and 71-6-121.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed September 21, 2001; effective December 5, 2001. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007.*

1200-8-25-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Only ACLF residents whose needs can be met by the facility within its licensure category shall be admitted. An appropriate ACLF resident is primarily an aged ambulatory person who requires domiciliary care and who may require non-medical living assistance services, medical services such as medication procedures and administration of medications that are typically self-administered, emergency response services, and home care organization services as prescribed by a physician's order and as allowed by law.

(Rule 1200-8-25-.05, continued)

(2) Except as provided in 1200-8-25-.05(3) and 1200-8-25-.05(5), an assisted care living facility shall not admit nor permit the continued stay of any assisted-care living facility resident if any of the following conditions exists. The person:

(a) Is in the latter stage of Alzheimer's disease or related disorders;

(b) Requires physical or chemical restraints;

(c) Poses a serious threat to himself or herself or others;

(d) Requires nasopharyngeal and tracheotomy aspiration;

(e) Requires initial phases of a regimen involving administration of medical gases;

(f) Requires a Levin (or nasogastric) tube;

(g) Requires arterial blood gas monitoring;

(h) Is unable to communicate his or her needs;

(i) Requires gastrostomy feedings;

(j) Requires intravenous or daily intramuscular injections or intravenous feeding;

(k) Requires insertion, sterile irrigation and replacement of catheters, except for routine maintenance of Foley catheters;

(l) Requires sterile wound care; or,

(m) Requires treatment of extensive stage 3 or stage 4 decubitus ulcer or exfoliative dermatitis.

(3) So long as (1) a person does not otherwise fall outside the definition of an assisted care living facility resident, and (2) the person's medical condition and overall health status are stable, and (3) the person is able to care for their condition without the assistance of facility personnel or home health care, and (4) the person has a documented history of self-care for their medical condition for at least one (1) year, which is documented by the patient's treating physician and made part of their medical record, then any assisted-care living facility may accept for admission and allow the continued stay of such person who:

(a) has in place a gastrostomy tube or percutaneous endoscopic gastrostomy tube;

(b) requires a nasopharyngeal suctioning or has a tracheostomy tube;

(c) has in place a catheter that is their sole physical means of elimination of waste; or

(d) requires the routine administration of oxygen; provided, however, with respect to this requirement, no such documented history of self-care for a person's medical condition for at least one (1) year shall be required for the continued stay of an assisted living facility resident.

(4) If any person admitted to an assisted care living facility under paragraph (3) above no longer meets the requirements listed above and/or is no longer able to self care for their medical condition, the assisted care living facility must transfer the person immediately to a licensed nursing home or hospital. However, this requirement shall not be construed to prevent facility staff from responding to an emergency situation.

(Rule 1200-8-25-.05, continued)

(5) A resident of an ACLF with any of the conditions listed in (a), (b), or (c) of this paragraph may be retained by the ACLF for a period not to exceed twenty-one (21) days. A resident may continue as a resident in the facility for an additional twenty-one (21) day period if, within the first twenty-one (21) days (or by the first business day thereafter, if the twenty-first day falls on a weekend or holiday), or earlier if the need for an extension becomes apparent to the facility, the extension of the initial twenty-one (21) day period is approved by the commissioner of health, or the commissioner's designee, so long as the individual approving the extension is a physician licensed in Tennessee. The Department must respond to a request for an extension of stay within five (5) working days of its receipt of an extension request.

(a) The person requires intravenous or daily intramuscular injections or intravenous feedings;

(b) The person requires insertion, sterile irrigation and replacement of catheters, except for routine maintenance of Foley catheters; or

(c) The person requires sterile wound care.

(6) Requests to the Department for twenty-one (21) day extensions shall be:

(a) Made in writing and transmitted by mail or fax within two (2) business days of the date that the need for an extension becomes apparent to the facility; and

(b) Include a detailed summary of the resident's condition.

(7) Under no circumstances shall a person be eligible to continue as an assisted care living facility resident if after the twenty-one (21) day period the resident requires four (4) or more skilled nursing visits per week for conditions other than those listed in paragraph (5) of this rule.

(8) The ACLF must:

(a) Be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and regulations, and those residents who should be transferred to a higher level of care.

(b) Have a written admission agreement that includes a procedure for handling the transfer or discharge of residents and that does not violate the residents' rights under the law or these rules.

(c) Have an accurate written statement regarding fees and services which will be provided upon admission.

(d) Give a thirty (30) day notice to all residents before any changes in fee schedules can be made.

(e) Ensure that residents see a physician for acute illness or injury and are transferred in accordance with any physician's orders.

(f) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident.

(Rule 1200-8-25-.05, continued)

The facility shall document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.

(g) Provide to the resident at the time of admission a copy of the Resident's Rights for the resident's review and signature. A signed copy must be provided to the resident at the time of admission.

(h) Have written policies and procedures to assist residents in the proper development, filing, modification and rescission of an advanced directive, a living will, a do-not-resuscitate order, and the appointment of a durable power of attorney for health care.

(9) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each assisted-care living facility shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

(10) Resident who cannot evacuate within thirteen (13) minutes may be retained in the facility so long as such residents are retained in designated areas in accordance with Chapter 12 of the 1997 edition of the NFPA Life Safety Code and Institutional Unrestrained Occupancy of the Standard Building Code.

(11) Persons in all but the latter stages of Alzheimer's Disease and Related Disorders may be admitted only after it has been determined by an interdisciplinary team consisting of, at a minimum, a physician experienced in the treatment of Alzheimer's Disease and Related Disorders, a social worker, a registered nurse, and a family member (or patient care advocate) that care can appropriately and safely be given in the facility. The interdisciplinary team must review such persons at least quarterly as to the appropriateness of placement in the facility.

(12) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(13) Facilities utilizing secured units must be able to annually provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:

(a) Documentation that each secured resident has been evaluated by an interdisciplinary team consisting of at least a physician, a social worker, a registered nurse, and a family member (or patient care advocate) prior to admittance to the unit;

(b) Ongoing and up-to-date documentation of quarterly review by each resident's interdisciplinary team as to the appropriateness of placement in the secured unit;

(c) A current listing of the number of deaths and hospitalizations, with diagnoses, that have occurred on the unit;

(d) A current listing of all unusual incidents and/or complications on the unit;

(e) An up-to-date staffing pattern and staff ratios for the unit that is recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake, on duty, and

(Rule 1200-8-25-.05, continued)

physically located on the unit twenty-four (24) hours per day, seven (7) days per week, at all times;

(f) A formulated calendar of daily group activities scheduled, including a resident attendance record for the previous three (3) months;

(g) An up-to-date listing of any incidences of decubitus and/or nosocomial infections, including resident identifiers; and

(h) Documentation showing that 100% of the staff working on the unit receives and has received annual in-service training which shall include, but not be limited to, the following subject areas:

1. Basic facts about the causes, progression and management of Alzheimer's Disease and related disorders;

2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;

3. Identifying and alleviating safety risks to the resident;

4. Providing assistance in the activities of daily living for the resident; and

5. Communicating with families and other persons interested in the resident.

(14) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-257.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed February 15, 2000; effective April 30, 2000. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007.*

1200-8-25-.06 PERSONAL SERVICES.

(1) Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of the resident's whereabouts and the ability and readiness to intervene if crises arise.

(2) Medication shall be self-administered, or administered by a licensed professional operating within the scope of his/her license who is employed by the ACLF or a licensed home care organization.

(3) Self-administration includes assistance in reading labels, opening dosage packaging, reminding residents of their medication, observing the resident while taking medication and checking the self-administered dose against the dosage shown on the prescription.

(4) All medications shall be stored so that no resident can obtain another resident's medication.

(5) All drugs and biologicals must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements.

(6) Residents shall be provided assistance, if needed, in all activities of daily living.

(7) The ACLF shall provide arrangements for laundry of linens for the home and for residents' clothing.

(Rule 1200-8-25-.06, continued)

(8) Appropriate separate storage areas for soiled linen and residents' clothing shall be provided.

(9) Clean linen shall be maintained in sufficient quantity to provide for the needs of the residents. Linens shall be changed whenever necessary.

(10) The ACLF must have organized dietary services that are directed and staffed by adequate qualified personnel. An ACLF may contract with an outside food management company if the company has a dietitian who serves the facility on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the facility for recommendations on dietetic policies affecting resident treatment.

(11) The ACLF must have an employee who:

(a) Serves as director of the food and dietetic service;

(b) Is responsible for the daily management of the dietary services and staff training; and

(c) Is qualified by experience or training.

(12) There must be a qualified dietitian, full time, part-time, or on a consultant basis.

(13) Menus must meet the needs of the residents.

(a) Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the residents.

(b) Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the residents.

(c) A current therapeutic diet manual approved by the dietitian must be readily available to all facility personnel.

(d) Menus shall be planned one week in advance.

(14) Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable and/or prescribed diet. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140ºF. or above) or cold (41ºF. or less). The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to patients with special dietary needs or upon request.

(15) Sufficient food provision capabilities and dining space shall be provided.

(16) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times.

(17) Appropriate equipment and utensils for cooking and serving food shall be provided in sufficient quantity to serve all residents and must be in good repair.

(18) The kitchen shall be maintained in a clean and sanitary condition.

(19) Equipment, utensils and dishes shall be washed and sanitized after each use.

(Rule 1200-8-25-.06, continued)

(20) A suitable and comfortable furnished area shall be provided in the facility for activities and family visits. Furnishings shall include a calendar and a functioning television set, radio, and clock.

(21) The facility shall provide current newspapers, magazines or other reading materials.

(22) The facility must have a telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000.*

200-8-25-.07 BUILDING STANDARDS.

(1) The assisted care living facility must be constructed, arranged, and maintained to ensure the safety of the resident.

(2) The condition of the physical plant and the overall assisted care living facility environment must be developed and maintained in such a manner that the safety and well-being of residents are assured.

(3) No new assisted care living facility shall hereafter be constructed, nor shall major alterations be made to existing assisted care living facilities, or change in an assisted care living facility type be made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new assisted care living facility is licensed or before any alteration or expansion of a licensed assisted care living facility can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

(4) After the application and licensure fees have been submitted, the building construction plans must be submitted to the department. All new facilities shall conform to the current addition of the Standard Building Code, the National Fire Protection Code (NFPA), the National Electrical Code, and the U.S Public Health Service Food Code as adopted by the Board for Licensing Health Care Facilities. When referring to height, area or construction type, the Standard Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are conflicts between requirements in the above listed codes and regulations and provisions of this chapter, the most restrictive shall apply.

(5) The codes in effect at the time of submittal of plans and specifications, as defined by these regulations shall be the codes to be used throughout the project.

(6) Review of plans and specifications shall be acknowledged in writing with copies sent to the architect and the owner, manager or other executive of the institution. The distribution of such review may be modified at the discretion of the department.

(7) All construction shall be executed in accordance with the approved plans and specifications.

(8) All new construction and renovations to assisted care living facilities, other than minor alterations not affecting fire and life safety or functional issues, shall be performed in accordance with the specific requirements of these regulations governing new construction in assisted care living facilities, including the submission of phased construction plans and the final drawings and the specifications to each.

(Rule 1200-8-25-.07, continued)

(9) In the event submitted materials do not appear to satisfactorily comply with 1200-8-25-.07 (4) the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

(10) Notice of satisfactory review from the department constitutes compliance with this requirement if construction begins within one hundred eighty (180) days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

(11) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.

(12) Prior to final inspection, a CD Rom disc, in TIF or DMG format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

(13) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot (1/8" = 1'), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. These plans shall be prepared by an architect or engineer licensed to practice in the State of Tennessee. The plans shall contain a certificate signed by the architect or engineer that to the best of his or her knowledge or belief the plans conform to all applicable codes.

(a) Two (2) sets of plans shall be forwarded to the appropriate section of the department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the understanding that such work is at the owner's risk and without assurance that final approval of final plans and specifications shall be granted. Final plans and specifications shall be submitted for review and approval. Final approval must be received before proceeding beyond foundation work.

(b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.

(14) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.

(15) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.

(16) Architectural drawings shall include:

(a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;

(b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;

(c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;

(Rule 1200-8-25-.07, continued)

(d) The elevation of each facade;

(e) The typical sections throughout the building;

(f) The schedule of finishes;

(g) The schedule of doors and windows;

(h) Roof plans;

(i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and

(j) Code analysis.

(17) Structural drawings shall include:

(a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;

(b) Schedules of beams, girders and columns; and

(c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.

(18) Mechanical drawings shall include:

(a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;

(b) Water supply, sewerage and HVAC piping systems;

(c) Pressure relationships shall be shown on all floor plans;

(d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;

(e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and,

(f) Color coding to show clearly supply, return and exhaust systems.

(19) Electrical drawings shall include:

(a) A certification that all electrical work and equipment is in compliance with all applicable local codes and laws, and that all materials are currently listed by recognized testing laboratories;

(b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;

(c) The electrical system shall comply with applicable codes, and shall include:

1. The fire alarm system; and

(Rule 1200-8-25-.07, continued)

2. The emergency power system including automatic services as defined by the codes.

(d) Color coding to show all items on emergency power.

(20) Sprinkler drawings shall include:

(a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;

(b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and

(c) Show "Point of Service" where water is used exclusively for fire protection purposes.

(21) No system of water supply, plumbing, sewage, garbage or refuse disposal shall be installed nor shall any existing system be materially altered or extended until complete plans and specifications for the installation, alteration or extension have been submitted to the department and show that all applicable codes have been met and necessary approval has been obtained.

(a) Before the facility is used, the water supply system shall be approved by the Tennessee Department of Environment and Conservation.

(b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.

(c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F.and 115°F.

(22) The following alarms are required and shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable)

(23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

(24) With the submission of plans the facility shall specify the evacuation capabilities of the residents as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

(25) A minimum of eighty (80) square feet of bedroom space must be provided each resident. No bedroom shall have more than two (2) beds. Privacy screens or curtains must be provided and used when requested by the resident.

(26) Living room and dining areas capable of accommodating all residents shall be provided, with a minimum of fifteen (15) square feet per resident per dining area.

(27) Each toilet, lavatory, bath or shower shall serve no more than six (6) persons. Grab bars and non-slip surfaces shall be installed at tubs and showers.

(Rule 1200-8-25-.07, continued)

(28) Each assisted-care living facility shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1999; effective February 8, 1999. Amendment filed August 26, 2002; effective November 9, 2002. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007.*

1200-8-25-.08 LIFE SAFETY.

(1) Any assisted care living facility which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The assisted care living facility shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for assisted care living facility personnel in each separate building. There shall be one fire drill per quarter during sleeping hours. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

(3) Residents who cannot evacuate within thirteen (13) minutes may be retained in the facility so long as such residents are retained in designated areas in accordance with of the Standard Building Code and the National Fire Protection Code (NFPA).

(4) Each resident’s room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.

(5) Doors to residents’ rooms shall not be louvered.

(6) Corridors shall be lighted at all times, to a minimum of one foot candle.

(7) General lighting and night lighting shall be provided for each resident. Night lighting shall be equipped with emergency power.

(8) Corridors and exit doors shall be kept clear of equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to a safe area.

(9) Combustible finishes and furnishings shall not be used.

(10) Open flame and portable space heaters shall not be permitted in the facility. Cooking appliances other than microwave ovens shall not be allowed in sleeping rooms.

(Rule 1200-8-25-.08, continued)

(11) All heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120°F.

(12) Fireplaces and/or fireplace inserts may be used only if provided with guards or screens which are secured in place. Fireplaces and chimneys shall be inspected and cleaned annually and verified documentation shall be maintained.

(13) All electrical equipment shall be maintained in good repair and in safe operating condition.

(14) Electrical cords shall not be run under rugs or carpets.

(15) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension cords shall not be used.

(16) All facilities must have electrically-operated smoke detectors with battery back-up power operating at all times in, at least, sleeping rooms, day rooms, corridors, laundry room, and any other hazardous areas.

(17) Fire extinguishers, complying with NFPA 10, shall be provided and mounted so they are accessible to all residents in the kitchen, laundries and at all exits. Extinguishers in the kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.

(18) Smoking and smoking materials shall be permitted only in designated areas under supervision. Ashtrays must be provided wherever smoking is permitted. Smoking in bed is prohibited. The facility shall have written policies and procedures for smoking within the facility which shall designate a room or rooms to be used exclusively for residents who smoke. The designated smoking room or rooms shall not be the dining room or activity room.

(19) No smoking signs shall be posted in areas where oxygen is used or stored.

(20) Trash and other combustible waste shall not be allowed to accumulate within and around the facility and shall be stored in appropriate containers with tight-fitting lids. Resident rooms shall be furnished with a UL approved trash container.

(21) All safety equipment shall be maintained in good repair and in a safe operating condition.

(22) Janitorial supplies shall not be stored in the kitchen, food storage area, dining area or resident accessible areas.

(23) Flammable liquids shall be stored in approved containers and stored away from the living areas of the facility.

(24) Floor and dryer vents shall be cleaned as frequently as needed to prevent accumulation of lint, soil and dirt.

(25) Emergency telephone numbers must be posted near a telephone accessible to the residents.

(26) The physical environment shall be maintained in a safe, clean and sanitary manner.

(a) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.

(Rule 1200-8-25-.08, continued)

(b) The building shall not become overcrowded with a combination of the facility's residents and other occupants.

(c) Each resident bedroom shall contain a chair, bed, mattress, springs, linens, chest of drawers and wardrobe or closet space, either provided by the facility or by the resident if the resident prefers. All furniture provided by the resident must meet NFPA. All residents' clothing must be maintained in good repair and suitable for the use of elderly persons.

(d) The building and its heating, cooling, plumbing and electrical systems shall be maintained in good repair and in clean condition at all times.

(e) Temperatures in residents' rooms and common areas shall not be less than 65°F.and no more than 85°F.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006.*

1200-8-25-.09 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each ACLF must develop, maintain and implement written policies and procedures for the definition and handling of its infectious waste. These policies and procedures must comply with the standards of this section.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";

(b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(c) Waste human blood and blood products such as serum, plasma, and other blood components;

(d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

(e) All discarded sharps (e.g., hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories;

(f) Other waste determined to be infectious by the facility in its written policy.

(3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the facility.

(4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste

(Rule 1200-8-25-.09, continued)

will be treated and disposed, and how it will be handled and transported, prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid, and puncture-resistant containers which must then be tightly sealed.

(b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (e.g., chemical, radiological) must also be conspicuously identified to clearly indicate those additional hazards.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(d) Opaque packaging must be used for pathological waste.

(5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary. Plastic bags of infectious waste must be transported by hand.

(6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

(a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does not create a nuisance.

(b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage.

(7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:

(a) Isolate the area from the public and all except essential personnel;

(b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph 6 of this section;

(c) Sanitize all contaminated equipment and surfaces according to written policies and procedures which specify how this will be done appropriately; and,

(d) Complete an incident report and maintain a copy on file.

(8) Except as provided otherwise in this rule a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.

(a) A facility may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfection cycle must contain appropriate indicators to assure that conditions were met for

(Rule 1200-8-25-.09, continued)

proper sterilization or disinfection of materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

(b) A facility may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to *T.C.A. §§ 69-3-101, et seq.*, provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.

(c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.

(9) The facility may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the facility must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.

(10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule.

(11) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material, and shall be kept on elevated platforms.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998.*

1200-8-25-.10 RECORDS AND REPORTS.

(1) An individual resident record and a complete medical record, if indicated, shall be maintained for each resident in the ACLF. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These records shall be retained for three (3) years after the resident is transferred or discharged.

(2) A current, complete resident record and a complete medical record, if indicated, shall be maintained for each resident in the facility. The resident record shall include:

(a) Name, Social Security Number, veteran status and number, marital status, age, sex, previous address and any health insurance provider and number, including Medicare and/or Medicaid numbers;

(Rule 1200-8-25-.10, continued)

(b) Name, address and telephone number of next of kin, legal guardian and/or any other person identified by the resident to contact on his/her behalf;

(c) Name, address and telephone number of any person or agency providing additional services to the resident;

(d) Date of admission, transfer, discharge and any new forwarding address;

(e) Name and address of the resident's preferred physician, hospital, pharmacist and nursing home, and any other instructions from the resident to be followed in case of emergency;

(f) Record of all monies and other valuables entrusted to the ACLF for safekeeping, with appropriate updates;

(g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any health care instructions; and,

(h) A copy of the admission agreement, signed and dated by the resident, including advance directives, DNR Order, Durable Power of Attorney, or living will, when applicable, and made available upon request to the facility.

(3) For those residents who require health care services, a medical record will be maintained, regardless of whether such services are rendered by facility staff or by arrangement with an outside source. The facility will develop a policy with each outside source to obtain up-to-date progress notes in a timely manner on each resident in its care. The medical record portion of the resident record shall include at least the following, in addition to the information required in (2)(e) and (g) above:

(a) Identification data;

(b) Medical history; including a physician's summary of the resident's medical condition at the time of admission;

(c) Resident's initial health care assessment, and subsequent assessments;

(d) Nursing records and progress notes from facility staff and/or those from an outside source;

(e) Treatment records;

(f) Physician's diagnostic, medication and therapeutic orders;

(g) Health care services plans addressing resident's medical care needs;

(h) Medication administration records; and,

(i) A copy of the completed Alzheimer quarterly reviews.

(4) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

(Rule 1200-8-25-.10, continued)

1. medication errors;

2. aspiration in a non-intubated patient related to conscious/moderate sedation;

3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

4. volume overload leading to pulmonary edema;

5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;

6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;

7. burns of a second or third degree;

8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

   (i) procedure related injury requiring repair or removal of an organ;

   (ii) hemorrhage;

   (iii) displacement, migration or breakage of an implant, device, graft or drain;

   (iv) post operative wound infection following clean or clean/contaminated case;

   (v) any unexpected operation or reoperation related to the primary procedure;

   (vi) hysterectomy in a pregnant woman;

   (vii) ruptured uterus;

   (viii) circumcision;

   (ix) incorrect procedure or incorrect treatment that is invasive;

   (x) wrong patient/wrong site surgical procedure;

   (xi) unintentionally retained foreign body;

   (xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;

   (xiii) criminal acts;

   (xiv) suicide or attempted suicide;

(Rule 1200-8-25-.10, continued)

(xv) elopement from the facility;

(xvi) infant abduction, or infant discharged to the wrong family;

(xvii) adult abduction;

(xviii) rape;

(xix) patient altercation;

(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

1. strike by the staff at the facility;

2. external disaster impacting the facility;

3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(c) For health services provided in a "home" setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department's approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final

(Rule 1200-8-25-.10, continued)

determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

(f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

(h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

(j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility.

(k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.

(l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

(5) The facility shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. The reports shall be maintained in a single file, and shall be made available for inspection during normal business hours to any resident who requests to view them. Each resident and each person assuming any financial responsibility for a resident must be fully informed, before admission, of the existence of the reports in the ACLF and given the opportunity to inspect the file before entering into any monetary agreement with the facility.

(a) Local fire safety inspections.

(Rule 1200-8-25-.10, continued)

(b) Local building code inspections, if any.

(c) Department licensure and fire safety inspections and surveys.

(d) Orders of the Commissioner or Board, if any.

(e) Maintenance records of all safety equipment.

(6) The Joint Annual Report of Assisted Care Living Facilities shall be filed with the department. The forms shall be furnished and mailed to each ACLF by the department each year and the forms must be completed and returned to the department as required.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed April 11, 2003; effective June 25, 2003.*

1200-8-25-.11 RESIDENT RIGHTS. Each resident has at least the following rights:

(1) To privacy in treatment and personal care;

(2) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department and the Tennessee Department of Human Services, Adult Protective Services at 1-888-277-8366;

(3) To refuse treatment. The resident must be informed of the consequences of that decision, the refusal and its reason must be reported to the physician and documented in the resident's record;

(4) To have his or her file kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law;

(5) To be fully informed of the Resident's Rights, of any policies and procedures governing resident conduct, any services available in the home and the schedule of all fees for all services;

(6) To participate in drawing up the terms of the admission agreement, including providing for the resident's preferences for physician care, hospitalization, nursing home care, acquisition of medication, emergency plans and funeral arrangements;

(7) To be given thirty (30) days written notice prior to transfer or discharge, except when ordered by any physician because a higher level of care is required;

(8) To voice grievances and recommend changes in policies and services of the facility with freedom from restraint, interference, coercion, discrimination or reprisal. The resident shall be informed of procedures for registering complaints confidentially and to voice grievances;

(9) To manage his or her personal financial affairs, including the right to keep and spend his or her own money. If the resident requests assistance from the home in managing his or her personal financial affairs, the request must be in writing and may be terminated by the resident at any time. The ACLF must separate such monies from the home's operating funds and all other deposits or expenditures, submit a written accounting to the resident at least quarterly, and immediately return the balance upon transfer or discharge. A current copy of this report shall be maintained in the resident's file maintained by the licensee;

(10) To be treated with consideration, respect and full recognition of his or her dignity and individuality;

(Rule 1200-8-25-.11, continued)

(11) To be accorded privacy for sleeping and for storage space for personal belongings;

(12) To have free access to day rooms, dining and other group living or common areas at reasonable hours and to come and go from the facility, unless such access infringes upon the rights of other residents;

(13) To wear his or her own clothes, to keep and use his or her own toilet articles and personal possessions;

(14) To send and receive unopened mail;

(15) To associate and communicate privately with persons of his or her choice, including receiving visitors at reasonable hours;

(16) To participate, or to refuse to participate, in community activities; including cultural, educational, religious, community service, vocational and recreational activities;

(17) To not be required to perform services for the home. The resident and licensee may mutually agree, in writing, for the resident to perform certain activities or services as part of the fee for his or her stay; and

(18) To execute, modify, or rescind a Living Will, Do-Not-Resuscitate Order or advance directive.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998.*

1200-8-25-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each assisted-care living facility shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a resident who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual residents. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the resident could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the resident could have made while having capacity.

(3) The advance directive shall be in writing, signed by the resident, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the resident by blood, marriage, or adoption and would not be entitled to any portion of the estate of the resident upon the death of the resident. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.

(4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the resident lacks capacity, and ceases to be effective upon a determination that the resident has recovered capacity.

(5) A facility shall use the mandatory advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.

(Rule 1200-8-25-.12, continued)

(6) A determination that a resident lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.

(7) An agent shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the resident's best interest. In determining the resident's best interest, the agent shall consider the resident's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the resident's residence.

(10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.

(11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.

(12) A resident having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(13) A resident having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.

(15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.

(b) A surrogate may make a health care decision for a resident who is an adult or emancipated minor if and only if:

1. the resident has been determined by the designated physician to lack capacity, and

2. no agent or guardian has been appointed, or

3. the agent or guardian is not reasonably available.

(c) In the case of a resident who lacks capacity, the resident's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the resident is receiving health care.

(Rule 1200-8-25-.12, continued)

(d) The resident's surrogate shall be an adult who has exhibited special care and concern for the resident, who is familiar with the resident's personal values, who is reasonably available, and who is willing to serve.

(e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:

1. the resident's spouse, unless legally separated;

2. the resident's adult child;

3. the resident's parent;

4. the resident's adult sibling;

5. any other adult relative of the resident; or

6. any other adult who satisfies the requirements of 1200-8-25-.12(16)(d).

(f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the resident shall be eligible to serve as the resident's surrogate.

(g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:

1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the resident or in accordance with the resident's best interests;

2. The proposed surrogate's regular contact with the resident prior to and during the incapacitating illness;

3. The proposed surrogate's demonstrated care and concern;

4. The proposed surrogate's availability to visit the resident during his or her illness; and

5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.

(h) If the resident lacks capacity and none of the individuals eligible to act as a surrogate under 1200-8-25-.12(16)(c) thru 1200-8-25-.12(16)(g) is reasonably available, the designated physician may make health care decisions for the resident after the designated physician either:

1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or

2. Obtains concurrence from a second physician who is not directly involved in the resident's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.

(i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.

(Rule 1200-8-25-.12, continued)

(j) A surrogate shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the resident's best interest. In determining the resident's best interest, the surrogate shall consider the resident's personal values to the extent known to the surrogate.

(k) A surrogate who has not been designated by the resident may make all health care decisions for the resident that the resident could make on the resident's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a resident upon a decision of the surrogate only when the designated physician and a second independent physician certify in the resident's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the resident is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 1200-8-25-.12(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and

2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the resident's treating health care provider.

(m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:

1. the employee so designated is a relative of the resident by blood, marriage, or adoption; and

2. the other requirements of this section are satisfied.

(n) A health care provider may require an individual claiming the right to act as surrogate for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the resident's individual instructions and may not revoke the resident's advance directive absent a court order to the contrary.

(b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) A health care provider may require an individual claiming the right to act as guardian for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(18) A designated physician who makes or is informed of a determination that a resident lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the resident's current clinical record and communicate the determination to the resident, if possible, and to any person then authorized to make health care decisions for the resident.

(19) Except as provided in 1200-8-25-.12(20) thru 1200-8-25-.12(22), a health care provider or institution providing care to a resident shall:

(Rule 1200-8-25-.12, continued)

(a) comply with an individual instruction of the resident and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the resident; and

(b) comply with a health care decision for the resident made by a person then authorized to make health care decisions for the resident to the same extent as if the decision had been made by the resident while having capacity.

(20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.

(21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:

(a) contrary to a policy of the institution which is based on reasons of conscience, and

(b) the policy was timely communicated to the resident or to a person then authorized to make health care decisions for the resident.

(22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-8-25-.12(20) thru 1200-8-25-.12(22) shall:

(a) promptly so inform the resident, if possible, and any person then authorized to make health care decisions for the resident;

(b) provide continuing care to the resident until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) unless the resident or person then authorized to make health care decisions for the resident refuses assistance, immediately make all reasonable efforts to assist in the transfer of the resident to another health care provider or institution that is willing to comply with the instruction or decision; and

(d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.

(24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a resident has the same rights as the resident to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

(25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(a) complying with a health care decision of a person apparently having authority to make a health care decision for a resident, including a decision to withhold or withdraw health care;

(b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(Rule 1200-8-25-.12, continued)

(c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

(26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

(27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.

(28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

(29) The withholding or withdrawal of medical care from a resident in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(30) Universal Do Not Resuscitate Order (DNR).

(a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a physician for his/her patient with whom he/she has a physician/patient relationship, but only:

1. with the consent of the patient; or

2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(b) If the resident is an adult who is capable of making an informed decision, the resident's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the resident is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the resident be resuscitated by the person authorized to consent on the resident's behalf shall revoke a universal do not resuscitate order.

(c) Universal do not resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.

(d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

(Rule 1200-8-25-.12, continued)

(e) If a person with a universal do not resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the resident in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the resident's record.

(f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a resident in the event of cardiac or respiratory arrest in accordance with accepted medical practices.

(g) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007.*

1200-8-25-.13 DISASTER PREPAREDNESS.

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans, for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans shall be readily available at all times. Each of the following plans shall be exercised annually:

(a) Fire Safety Procedures Plan shall include:

1. Minor fires;

2. Major fires;

3. Fighting the fire;

4. Evacuation procedures; and

5. Staff functions.

(b) Tornado/Severe Weather Procedures Plan shall include:

1. Staff duties; and

2. Evacuation procedures.

(c) Bomb Threat Procedures Plan:

1. Staff duties;

2. Search team, searching the premises;

(Rule 1200-8-25-.13, continued)

3. Notification of authorities;

4. Location of suspicious objects; and,

5. Evacuation procedures.

(d) Flood Procedure Plan, if applicable:

1. Staff duties;

2. Evacuation procedures; and

3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedure Plans:

1. Staff duties;

2. Equipment failures;

3. Evacuation procedures; and

4. Emergency food service.

(f) Earthquake Disaster Procedures Plan:

1. Staff duties;

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

(3) For facilities which elect to have an emergency generator, the generator shall be designed to meet the facility's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with the local resources.

(a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.

(b) The emergency generator shall be operated at the existing connected load and not on dual power, and a monthly log shall be maintained by the facility. The facility shall have trained staff familiar with the generator's operation.

Authority: *T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998.*

1200 8-25-.14 APPENDIX I.

(1) Physician Orders for Scope of Treatment (POST) Form

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name
This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	First Name/Middle Initial
	Date of Birth

Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing. ☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitate (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C, and D.
Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. ☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions:_____
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions: ☐ No Antibiotics ☐ Antibiotics Other Instructions:_____
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible. ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:_____
Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other:_____(Specify) The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)_____
	Physician Name (Print) / Physician Phone Number / Office Use Only

(Rule 1200-8-25-.14, continued)

	Physician Signature (Mandatory)	Date	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

(Rule 1200-8-25-.14, continued)

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.

☐ Yes ☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

(Rule 1200-8-25-.14, continued)

☐ Yes ☐ No	Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE:_____
(Patient)

Witnesses:

1, I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. _____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. _____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF_____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)

(Rule 1200-8-25-.14, continued)

- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007.*